STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155690	A. BUILDING _____ B. WING _____	C 08/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW BROOK REHABILITATION CENTRE & SUITES	1821 LINDBERG RD ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaints IN00094530 and IN00094545.

Complains IN00094530 substantiated, no deficiencies related to the allegation are cited.

Complaint IN00094545 unsubstantiated, due to lack of evidence.

Survey dates: August 4, 5, 2011

Facility number: 000027
Provider number:155690
Aim number: 100266180

Surveyor: Jeri Curtis, RN

Census bed type:
SNF: 15
SNF/NF: 57
Other: 72

Census payor type:
Medicare: 14
Medicaid: 51
Other: 7
Total: 72

Sample: 5

Meadow Brook Rehabilitation Centre & Suites was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaints IN00094530 and IN00094545.

Quality review completed 8/9/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155690	A. BUILDING _____ B. WING _____	C 08/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW BROOK REHABILITATION CENTRE & SUITES	1821 LINDBERG RD ANDERSON, IN 46012

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F 000	Continued From page 1 Cathy Emswiller RN	F 000		